Physician Documentation *Willis Knighton South*

Name: Aaliyah Henderson
Age: 4 yrs **Sex:** Female **DOB:** 10/01/2013
Arrival Date: 02/10/2018 **Time:** 01:54
Bed 20

MRN: 11162
Account#: K
Private MD:

EXHIBIT tabbies 1

HPI:

02/10 02:33 This 4 yrs old Black/African Am Female presents to ED via Ambulatory with complaints of **Breathing Difficulty, Asthma Exacerbation**. dre/mj2

02:33 Onset: The symptoms/episode began/occurred at 00:00. The patient has been recently seen by a physician: SEEN AT QUICK CARE THURSDAY, DX WITH URI/STREP GIVEN Z PAK. HX AUTISM, ASTHMA, HAS BREATHING MACHINE AT HOME-ALBUTEROL, ONE TX PTA. The patient presents to the emergency department with cough, wheezing. Associated signs and symptoms: Pertinent positives: cough, wheezing, Pertinent negatives: abdominal pain, body aches, chest pain, constipation, diarrhea, dysuria, earache, fever, headache, myalgias, nasal discharge, seizure, sore throat, vomiting. Modifying factors: The patient symptoms are alleviated by nothing, the patient symptoms are aggravated by nothing. The patient has experienced a previous episode. dre/mj2

Historical:

- **Allergies:** Codeine; FISH PRODUCT DERIVATIVES;
- **Home Meds:**
  1. Albuterol Inhl as needed
  2. dulera 2 puffs am and 2 puffs pm
  3. Singulair PO nightly
- **PMHx:** Asthma; Autism
- **PSHx:** None

Historical:

02:11 Family history: No immediate family members are acutely ill. Immunization history: Childhood immunizations up to date, Last flu immunization: up to date. Social history: The patient lives at home with mother The patient attends nursery school the patient is a minor. sr11

02:33 The history from nurses notes was reviewed and confirmed. dre/mj2

ROS:

02:33 **Eyes:** Negative for injury, pain, redness, and discharge, **ENT:** Negative for injury, pain, and discharge, **Neck:** Negative for injury, pain, and swelling, **Cardiovascular:** Negative for chest pain, palpitations, and edema, **Abdomen/GI:** Negative for abdominal pain, nausea, vomiting, diarrhea, and constipation, **Back:** Negative for injury and pain, **GU:** Negative for injury, bleeding, discharge, and swelling, **MS/Extremity:** Negative for injury and deformity, **Skin:** Negative for injury, rash, and discoloration, **Neuro:** Negative for headache, weakness, numbness, tingling, and seizure. ROS as in the HPI, and all other systems were reviewed negative, or noncontributory, except as mentioned below. **Constitutional:** Positive for coughing, shortness of breath, Negative for chills, fatigue, malaise, acute pain, poor PO intake, vomiting, weight loss. **Respiratory:** Positive for cough, wheezing, Negative for dyspnea on exertion, hemoptysis, orthopnea, pleurisy, paroxysmal nocturnal dyspnea, sputum production. dre/mj2

Exam:

02:33 dre/mj2

Head/Face: Normocephalic, atraumatic.
Eyes: Pupils equal round and reactive to light, extra-ocular motions intact. Lids and lashes normal. Conjunctiva and sclera are non-icteric and not injected. Cornea within normal limits. Periorbital areas with no swelling, redness, or edema.
ENT: Nares patent. No nasal discharge, no septal abnormalities noted. Tympanic membranes are normal and external auditory canals are clear. Oropharynx with no redness, swelling, or masses, exudates, or evidence of obstruction, uvula midline. Mucous membrane moist
Neck: Trachea midline, no thyromegaly or masses palpated, and no cervical lymphadenopathy. Supple, full range of motion without nuchal rigidity, or vertebral point tenderness. No Meningismus. Lymphatic No abnormal lymphadenopathy noted by palpation in the neck or axilla
Chest/axilla: Normal symmetrical motion. No tenderness. No crepitus. No axillary masses or tenderness.

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Cardiovascular: Regular rate and rhythm with normal S1 and S2. no murmurs, rubs or gallops. Pulses intact and symmetrical throughout. No edema or JVD.
Abdomen/GI: Soft, non-tender, nondistended, no mass, no hepatosplenomegaly. No rebound or guarding. Bowel sounds present all quadrants. No hernia noted
Back: No spinal tenderness. No costovertebral tenderness. Full range of motion.
Skin: Warm and dry with excellent turgor. capillary refill <2 seconds. No cyanosis, pallor, rash or edema.
MS/ Extremity: Pulses equal, no cyanosis. Neurovascular intact. Joints show full, normal range of motion. Good muscle tone and strength. No acute changes of nails or digits
Neuro: Awake or easily awakened, alert, makes good eye contact, age appropriate reflexes, good tone, easily consolable.
Constitutional: The patient appears Blood pressure, pulse, respirations and temperature noted. awake, alert, well developed, well groomed, well hydrated, well nourished, non-diaphoretic, non-toxic, afebrile.
Respiratory: the patient does not display signs of respiratory distress, Respirations: normal, symetrical, no use of accessory muscles, no grunting, no evidence of nasal flaring, no appreciated paradoxical movements, no prolonged exhalations, no pursed lip breathing, no retractions, no shallow respirations, no splinting, no tachypnea, Breath sounds: rales, are not appreciated, rhonchi, are not appreciated, wheezing, that is mild, bronchial sounds, are not appreciated, decreased breath sounds, are not appreciated, stridor, is not appreciated.

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Height	Pain	Staff
02:05		156	36	99.3	91% on R/A	18.14 kg / 39 lbs 16 oz	3 ft. 2 in. (96.52 cm)		sr11
03:23		145	34		99%				sr11

02:05 Body Mass Index 19.47 (18.14 kg, 96.52 cm) sr11
02:05 100% breathing treatment sr11

Glasgow Coma Score:

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
02:05	spontaneous(4)	oriented(5)	obeys commands(6)		15	sr11

MDM:

02:30 Patient medically screened. dre

02:33 dre/mj2
Data interpreted: Pulse oximetry: on room air observed by me at the bedside is 91 %.

03:50 dre
Differential diagnosis: bacterial infection, bronchitis, fever, gastroenteritis, pneumonia URI, UTI, viral Infection.
Data reviewed: vital signs, nurses notes, lab test result(s), radiologic studies.
Counseling: I had a detailed discussion with the patient and/or guardian regarding: the historical points, exam findings, and any diagnostic results supporting the discharge/admit diagnosis, lab results, radiology results, the need for outpatient follow up.
Response to treatment: the patient's symptoms have resolved after treatment, the patient's condition has returned to base line.

Order	Status	Time	By	For
DuoNeb 1 unit dose Inhalation once	Ordered	02/10/18 02:04	sr11	dre
	Administered	02/10/18 02:04	sr11	
Notes:	**Order Method:** Verbal - Read back			
	Sign off: Easterling, David 02/10/18 02:31			

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02/10/18 02:04	**Administered:** DuoNeb 1 unit dose Inhalation	sr11
02/10/18 02:32	**Follow Up:** Response: No Adverse Reaction; Respiratory status improved; Tolerated well	sr11

Order	Status	Time	By	For
Influenza by PCR	Ordered	02/10/18 02:31	dre	dre
	Reviewed	02/10/18 03:10	David Easterling	
Notes:	**Order Method:** Electronic			

Interpretation: negative.
Ordering Location: ERSPC100.1
Priority LAB: Stat
Collected by Nurse? (Yes - Change to No for Lab Collect): Yes
Specimen Source (LBFLUSPEC): Nasopharynx

Order	Status	Time	By	For
COLLECT SWAB	Ordered	02/10/18 02:31	dre	dre
	Completed	02/10/18 02:32	Susan Rainer	
Notes:	**Order Method:** Electronic			

Order	Status	Time	By	For
Chest 2 View *routine*	Ordered	02/10/18 02:31	dre	dre
	In Process Unspecified	02/10/18 03:39	Dispatcher MedHost	
Notes: Bed Name: 20	**Order Method:** Electronic			

Interpretation: perihilar infiltrates, otherwise negative .
Is the patient able to bear weight? (OERDBEARWT):
Is the patient at risk for falls? (OERDFALLS):
MODE OF TRANSPORTATION : (OERDTRANS): Stretcher
O2: (OEADO2): No
Priority RAD: Stat
REASON FOR EXAM: (OERDEXAM): Breathing Difficulty, Asthma Exacerbation
WEIGHT? : (OERDWEIGHT): 18.14
ER EXAM ROOM/BED: (OERDERRMBD): 20

Order	Status	Time	By	For
Call X-Ray Tech	Ordered	02/10/18 02:31	dre	dre
	Completed	02/10/18 02:36	Susan Rainer	
Notes:	**Order Method:** Electronic			

Order	Status	Time	By	For
Albuterol One Unit Dose (6kg & up) - Albuterol 2.5 mg Inhalation once	Ordered	02/10/18 03:11	dre	dre
	Administered	02/10/18 03:16	sr11	
Notes:	**Order Method:** Electronic			

Physician Documentation Con't.

02/10/18 03:16	**Administered:** Albuterol One Unit Dose (6kg & up) - Albuterol 2.5 mg Inhalation	sr11
02/10/18 03:55	**Follow Up:** Response: No Adverse Reaction; Respiratory status improved; Tolerated well	sr11

Order	Status	Time	By	For
Decadron - Dexamethasone Sodium Phosphate 4 mg IM once	Ordered	02/10/18 03:12	dre	dre
	Administered	02/10/18 03:44	mh7	
Notes:	**Order Method:** Electronic			

02/10/18 03:44	**Administered:** Decadron - Dexamethasone Sodium Phosphate 4 mg IM in left ventrogluteal	mh7
02/10/18 04:00	**Follow Up:** Response: No Adverse Reaction; Tolerated well	sr11

Order Signatures:

Easterling, David, MD	MD	dre	Rainer, Susan, RN	RN	sr11

Scribe Statement:

02/10
02:13 Scribed for **Dr. David R Easterling, MD** by Morgan Jaudon, Scribe dre/mj2

Disposition:

03:50 Electronically signed by: David Easterling, M.D. I personally performed the services described in this documentation as scribed in my presence and it is both accurate and complete. Disposition. dre

Disposition:

02/10/18 03:52 Discharged to Home/Self Care. Impression: Acute bronchospasm.

- Condition is Stable.
- Discharge Instructions: Bronchospasm, Pediatric.
- Prescriptions for
  prednisolone 15 mg/5 mL Oral Solution
  - take 10 milliliter by ORAL route once daily for 5 days with food; 50 milliliter.
- Follow up: Allen, Scott; When: 2 days; Reason: Recheck today's complaints.
- Problem is an acute exacerbation.
- Symptoms are resolved.

Signatures:

Easterling, David, MD	MD	dre	Jaudon, Morgan, Scribe	Scribe	mj2
Harmon, Melissa, RN	RN	mh7	Rainer, Susan, RN	RN	sr11

Nurse's Notes

Name: Aaliyah Henderson
Age: 4 yrs **Sex:** Female **DOB:** 10/01/2013
Arrival Date: 02/10/2018 **Time:** 01:54
Bed 20

Willis Knighton South

MRN: 1116206
Account#: K20034594943
Private MD: Allen, Scott

Presentation:

02/10 02:05 Presenting complaint: Mother states: woke up at midnight wheezing and coughing, i took her to quick care the other day, she has strep throat and URI, shes been taking a z pack, gave breathing treatment at home with no relief, pt currently sitting in tripod position. Preferred language for medical communication is English. Person Transporting: Parent. Transition of care: patient was not received from another setting of care. Mechanism of Injury: denies injury. Care prior to arrival: Medications: Albuterol Neb. sr11

02:11 Acuity: 2 - Emergent. sr11

02:15 Method of Arrival: Ambulatory. sr11

Triage Assessment:

02:05 **Pain:** level that is acceptable is 0 out of 10 on a pain scale. **General:** Appears well developed, well nourished, well groomed, distressed, uncomfortable, Behavior is appropriate for age, anxious, mobility; ambulates without assistance. sr11

Historical:

- **Allergies:** Codeine; FISH PRODUCT DERIVATIVES;
- **Home Meds:**
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02:33 The history from nurses notes was reviewed and confirmed. dre/mj2

Screening:

02:05 **Abuse screen:** Denies threats or abuse. Denies injuries from another. there are no obvious signs of child abuse. sr11
Patient fall risk assessment;
No risks identified.
Learning Barriers:
No barriers to teaching and learning identified.
Pedi Fall Risk
No risks identified.
Exposure risk/Travel Screening:
No exposures identified.

Assessment:

02:11 **Pain:** Denies pain. level that is acceptable is 0 out of 10 on a pain scale. **General:** Appears well developed, well nourished, well groomed, distressed, uncomfortable, Behavior is appropriate for age, anxious, mobility; ambulates without assistance. **Neuro:** Level of Consciousness is alert, awake, obeys commands. **EENT:** Reports Sore Throat Parent/caregiver reports the patient having nasal congestion nasal discharge. **Cardiovascular:** Capillary refill < 3 seconds is brisk in bilateral fingers Rhythm is sinus tachycardia. **Respiratory:** Respiratory effort is labored, with retractions, using tripod position, Respiratory pattern is tachypnea Airway is patent Breath sounds with wheezes bilaterally. **Dermatologic:** Skin is intact, is healthy with good turgor, Skin is pink, warm & dry. normal. sr11

02:33 **Respiratory:** Reassessment: Patient states symptoms have improved. sr11

Vital Signs:

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02:05 Body Mass Index 19.47 (18.14 kg, 96.52 cm) sr11

Nurse's Notes Con't

02:05 100% breathing treatment sr11

Vitals:

02:05 Acuity: 2 - Emergent. sr11

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ED Course:

01:54 Patient arrived in ED. ms2

01:54 Patient moved to KIOSK. ms2

02:04 Patient moved to 20. sr11

02:04 Rainer, Susan, RN is Primary Nurse. sr11

02:11 Triage completed. sr11

02:11 Patient/caregiver encouraged to voice any concerns. Side rails up X 1. Bed in low position. Child being held by parent. Pulse oximetry, Bedside monitor alarms on and audible. sr11

02:13 Easterling, David, MD is Attending Physician. dre

02:15 Allen, Scott is Private Physician. sr11

02:33 Influenza culture sent to lab. sr11

02:46 Patient moved to Radiology. jat

02:46 Chest 2 View *routine* Sent. jat

03:29 Patient moved to 20. jat

03:51 Allen, Scott is Referral Physician. dre

03:59 No procedures done that require assistance. sr11

Administered Medications:

Time	Drug & Dose *Dispensable & Quantity*	Volume	Route	Rate	Infused Over	Site	Delivery	Staff
02:04	DuoNeb 1 unit dose		Inhalation					sr11
02:32	Follow up: Response: No Adverse Reaction; Respiratory status improved; Tolerated well							sr11
03:16	Albuterol One Unit Dose (6kg & up) - Albuterol 2.5 mg		Inhalation					sr11
03:55	Follow up: Response: No Adverse Reaction; Respiratory status improved; Tolerated well							sr11
03:44	Decadron - Dexamethasone Sodium Phosphate 4 mg		IM			left ventrogluteal		mh7
04:00	Follow up: Response: No Adverse Reaction; Tolerated well							sr11

Outcome:

03:52 Discharge ordered by MD. dre

03:59 Discharged to home, ambulatory, with family. Discharge instructions given to Mother Instructed on discharge instructions, follow up and referral plans, medication usage, Demonstrated understanding of instructions, medications, Prescriptions given; 1, No questions or concerns expressed to me at discharge. No belongings were removed by WK staff. **Medication reconcilliation form provided. Med Effects:** Effects of administered medications were addressed. **Oxygen use:** Oxygen use not applicable. sr11

Nurse's Notes Con't

04:00 Electronic medical record closed. sr11

Signatures:

Easterling, David, MD	MD	dre	Scriptuser, MEDHOST		ms2
Torres, Jose		jat	Jaudon, Morgan, Scribe	Scribe	mj2
Harmon, Melissa, RN	RN	mh7	Rainer, Susan, RN	RN	sr11